National Institute on Drug Abuse
Therapy Manuals for Drug Addiction

A Community Reinforcement Approach: Treating Cocaine Addiction

Clinical Approach

While therapists must develop their own style of counseling, CRA + Vouchers therapists must also adopt certain guidelines to assure the integrity of the treatment. The guidelines presented here are designed to facilitate adherence to this treatment protocol. They reflect a treatment philosophy and conceptualization of drug dependence that is consistent with scientific studies on determinants of drug abuse. Since this approach differs at times from other perspectives on drug dependence, such as the disease model and self-medication model, the counseling approach also differs in some respects.

Counseling Style

Flexibility

Flexibility in appointment scheduling and goal setting is important for both treatment retention and facilitating progress toward target goals. Particularly in the initial stages of treatment, therapists must try to work around patients' schedules and make counseling as convenient for them as possible. The therapist's attitude should reflect an effort to meet the individual patient's needs.

Some patients may be oppositional, disorganized, inflexible, or ambivalent about participating in treatment. From a CRA + Vouchers perspective, such characteristics are part of the drug-dependence problem and thus behaviors that need to be changed over time. For example, therapists should -

- Tolerate tardiness to sessions and try to have a full session
- even when patients are late.
- Tolerate patients who must leave early from sessions.
- Be willing to meet patients almost any time of day.
- Set up meetings out of the office if necessary.

With difficult patients, once an effective working relationship is established, the therapist can begin to ask for more reasonable behavior regarding scheduling and regular participation. Improvements in these areas should become an explicit part of the individualized treatment plan. Usually such a plan involves graded steps toward improvements (i.e., shaping by successive approximation).

Flexibility in goal setting is also very important. For example, if the therapist thinks alcohol abstinence should be a goal but the patient is unwilling to accept that goal, a compromise is reached. Similarly, if the therapist thinks that regular employment should be a goal but the patient voices strong resistance, it is put on hold. In general, therapists should express what

they think are optimal goals, but if patients are not ready to make these changes, their positions are respected. The therapist's goal then becomes helping patients progress to the point where they may want to work on these goals. In the meantime, alternative goals are set, and the issues that were met with resistance can continue to be discussed during the course of treatment.

Empathy

Therapists must exhibit empathy and good listening skills. They should convey an understanding of the patient's situation and its inherent difficulties. In the initial stage of treatment, active listening skills can be used to help develop an effective relationship and to facilitate goal-setting. As a general rule, confrontation is strongly discouraged as a means of gaining compliance with therapeutic activities and goals. Rather, therapists should use their professional counseling skills and appropriate behavioral procedures (e.g., prompts, shaping successive approximations, social reinforcement) to gain treatment compliance.

For example, if patients are constantly late for appointments, therapists should not lecture them on promptness or lack of motivation but, instead, facilitate a discussion about the time demands of treatment and how they may conflict with important or desirable activities. Therapists can then engage the patients in problemsolving and ask them whether changing the appointment times or providing assistance with transportation would make it easier for them to attend regularly.

Throughout treatment, empathy should be shown whenever patients are ambivalent about or having difficulty making changes in any problem area. Nonjudgmental feedback is used to help patients make decisions about specific goals or lifestyle changes. Therapists avoid making moral or value judgments and, instead, exhibit genuine empathy and consideration for the difficult decisions and behavior changes patients must contemplate.

Active Involvement

CRA + Vouchers requires both therapists and patients to adopt an active, can-do, make-it-happen attitude throughout treatment. Active problemsolving becomes a routine part of the therapeutic relationship. Therapists do whatever it takes to help patients make lifestyle changes. This includes taking patients to appointments or job interviews, initiating recreational activities with them, scheduling sessions at different times to accomplish specific goals, having patients make phone calls while in the office, assisting them with appointments, and searching newspapers for job possibilities or recreational events.

The therapist's motto is "we can make it happen." Therapists try to model and in other ways facilitate this same attitude in patients. Patients should be encouraged to be doers rather than talkers, and therapists must model action behavior whenever appropriate.

One caution. Therapists must always use good judgment regarding their own safety when planning outreach interventions. Some patients or their living environments may present some cause for concern. In those instances, other staff members should go with the therapist. If staff are still not comfortable with the safety issues, the intervention should be postponed or canceled.

Directive but Collaborative

CRA + Vouchers treatment encourages patients to set lifestyle change goals. Therapists

guide the patients in setting appropriate and effective goals by enlisting information and suggestions from them. Therapists are also expected to have ideas about specific behavior changes necessary for increasing cocaine abstinence and ways to implement such changes. However, therapists must be careful not to present their views in an authoritarian style that makes patients feel that they are being told what to do. The task is to have patients actively participate in the development of their treatment plan so they feel that the plan is theirs.

Therapists should assume the role of both teacher and coach when helping patients develop new skills and behavior patterns. They can provide expert knowledge to help solve the problems for which the patients ask for help and then coach, train, and encourage patients as they try to put these skills into action.

Social Reinforcement

Therapists should provide social reinforcement frequently for all appropriate efforts and changes exhibited by patients. They should take advantage of all opportunities to help patients feel that they are making progress. This is important because, for many patients, change will be slow and difficult. The social reinforcement provided by therapists and clinic staff may be the only source of reward and encouragement available to patients during the early stages of the program.

Counseling Techniques

Therapists using CRA + Vouchers must have a good understanding of behavioral principles as well as sound counseling skills. A good working knowledge of behavioral principles and their application will allow therapists to effectively provide rationales for each treatment component, model appropriate skills, and serve as credible, competent professionals who can help people with many difficult issues.

Behavioral Techniques

As patients try to take active steps toward specific lifestyle changes, therapists should *not* expect them to readily set appropriate goals, initiate goal-directed behavior, and maintain these new behaviors simply because a well-meaning person encourages them to do so. Significant obstacles will arise that will make the targeted lifestyle changes difficult to achieve.

For example, engaging in a new prosocial recreational activity may involve interaction with nondrug users unfamiliar to the patient. The thought of entering this situation can produce anxiety and avoidance behavior. Similar obstacles may arise when patients try to attend educational classes, go for job interviews, or ask someone for a date. Explanations for noncompliant behavior may include lack of the skills necessary to complete the task, avoidance due to a history of prior failure in similar situations, and loss of something valued by the patient if change is implemented, to name a few possibilities. The therapists' responsibility is to maximize the probability that patients will carry through and achieve the desired behavior change. Behavioral procedures are the therapeutic tools used to increase the probability of compliance with therapeutic activities and success in meeting goals.

Some of the most important and frequently used behavioral principles and procedures that CRA + Vouchers therapists must master are -

- Behavioral contracting.

- Effective goal-setting.
- Modeling/role playing.
- Shaping successive approximations.
- Self-monitoring.
- Therapist prompting/monitoring.
- The Premack principle.
- Skills training (e.g., social skills, problemsolving, task analysis, relaxation, time management).

Additional Resources

It is beyond the scope of this manual to provide training or guidelines for how and when to apply basic behavioral procedures that will help patients meet targeted lifestyle change goals. Detailed protocols are provided for some of the procedures that are primary components of CRA + Vouchers, but in general, therapists must be experienced in applying behavioral procedures or be supervised by someone who has that experience. The following texts are recommended to help train and guide therapists in basic behavioral principles and procedures.

- Goldfried, M.R., and Davison, G.C. *Clinical Behavior Therapy* . New York: John Wiley and Sons, 1994.
- Meichenbaum, D., and Turk, D. *Facilitating Treatment Adherence: A Practitioner's Guidebook.* New York: Plenum Press, 1987.
- Miller, L.K. *Behavior Analysis for Everyday Life* . Pacific Grove, CA: Brooks/Cole, 1984.
- Sulzer-Azaroff, B., and Meyer, G.R. *Behavior Analysis for Lasting Change.* Fort Worth, TX: Holt Rinehart and Winston, 1991.

Progress Graphs

An effective way to demonstrate progress, or lack of it, to patients is to set measurable goals and record progress on graphs. The most important would be the cocaine urinalysis graph. This shows the cumulative number of cocaine-negative test results plotted as a function of consecutive tests conducted to date in treatment. Clinic attendance can also be presented graphically.

Specific target behaviors can be recorded on graphs so that progress can easily be viewed by both patient and therapist. For example, if the goal is to make four job contacts each day, a bar graph with days of the week on the x axis and number of job contacts on the y axis would be created, and a goal line set at four would be drawn across the graph. If the goal is to spend 10 hours each week in social/recreational activities, a cumulative record, by week, might be used to record progress.

Counseling Structure

The therapist's primary role in each session is to gain active participation from patients and to make sure the session stays focused on a preset plan. The task may be made difficult if the cocaine abuser comes to sessions with clinical issues other than those included in the treatment plan. To effectively deal with such issues, the therapist must skillfully demonstrate appropriate concern but not allow the session to lose focus. The session plan should be followed in every session, except in extreme emergencies. The plan can be structured to accommodate unexpected issues without necessarily altering the preset goals for the session. The therapist's task is to stay in control of the session and ensure that adequate time is available to cover the designated issues.

Preparation

Therapists should prepare for each session by reviewing the rationale for the component to be delivered as well as any didactic material to be presented. Prior to each session, a therapy session checklist **(exhibit 2)** is completed to ensure adequate preparation. The checklist provides the structure and guidance needed to stay focused on the task so that the treatment goals are covered in each session.

Session Protocol

The following protocol is followed for each session.

1. First, the therapist *reviews urinalysis results* (using the graph) with the patients and provides appropriate feedback. Any problems in the area of drug abstinence are discussed. Active listening skills are used to provide support, while encouragement and social reinforcement are used selectively to support the patients' efforts.
    - If the day's urine sample is *cocaine-negative*, patients are congratulated and the behavior that helped them remain abstinent is discussed.
    - If the day's urine sample is *cocaine-positive*, patients are reassured that cocaine use is their reason for being in treatment and that the treatment program is there to help with this problem. A functional analysis of the most recent cocaine use is conducted, and the therapist stresses the importance of understanding the reasons behind that behavior so they can better learn to control their use.
2. The therapist then *reviews and evaluates progress on each treatment goal* . Graphs are updated and any problems are discussed. Active listening skills are used to provide support; encouragement and social reinforcement are used selectively to support patients' efforts.
3. If adequate progress is not being made, *problemsolving and appropriate behavioral procedures* are used to resolve any difficulties that may be interfering with achieving the targeted goals.
4. After reviewing progress in each problem area, *goals to be met by the next session are set*. Didactic teaching and rationales for new behavioral targets are discussed with the patient.
5. *Skills training, behavioral rehearsal, and role playing* are used as scheduled and when appropriate.
6. *Out-of-office procedures* can be implemented when warranted. For example, if the week's goal is to sample a recreational activity and the therapist is to function as the initiator, then the patient and therapist go perform this activity. If the patients' goal was to fill out employment applications and they did not do so, then the therapist

helps them do so during the session.

7. *Disulfiram compliance* is reviewed and evaluated with patients who are involved in that protocol. Any problems with the disulfiram therapy are discussed and procedures implemented to resolve such problems. Reinforcement and encouragement are provided for successful compliance. Similarly, the compliance procedures for taking disulfiram at the clinic are followed with patients engaged in this protocol.
8. A *review of goals* to be accomplished between this session and the next, along with some words of encouragement, are the last things that happen in a session.

Recent Problems or Crises

Many cocaine abusers come to sessions each week with new or repeated crises. How the therapist handles such crises is important for the effective delivery of this treatment because CRA + Vouchers requires careful focus and structure. Certainly, ignoring patients' real life problems entails the risk that they will view treatment as irrelevant to their own needs, which may increase attrition. At least three options for handling crisis situations are available.

- Therapists can use their counseling skills to try to tie these seemingly unrelated issues back to the patient's treatment plan by discussing how the current treatment plan may help with the crisis.
- Therapists can discuss the importance of these issues while carefully explaining that these issues cannot be worked on until a period of abstinence has been achieved. If the strategies currently being tried are inappropriate or unsuccessful, a plan is discussed to better meet the patient's needs.
- Sessions are divided so that 10 - 20 minutes are available *at the end of a session* to discuss issues not directly related to the treatment plan. This strategy is an effective way to meet the patient's needs and retain the structured protocol. Importantly, the therapist can use attention to the patient-specified issue as reinforcement for covering the session plan (the Premack principle). A statement like the following can be very effective: "Yes, I can see why you are concerned about this matter. Let's try to get through some of our other issues so we can reserve time to talk about this." The order of events is important here. Attention to the new concern must come after going through the planned activity.

If therapists feel that an intervention is necessary for the new concern, then a behavioral approach consistent with the structure of CRA + Vouchers is used to assist the patient. Referral to an outside source may be an option if the problem is clearly in need of immediate attention and is not tied to drug abuse. The clinical supervisor is consulted to help resolve such issues. Trained therapists obviously must use their clinical judgment in dealing with such patient concerns. For example, one would not implement the aforementioned strategy in dealing with acute suicidality.

Special Issues

Absences

If patients do not come for a scheduled session or urinalysis test, an immediate attempt is made to contact them by telephone to find out why they missed the session. If patients do not have a telephone, a visit to their home is considered. Once contact is made, staff can encourage the patient to come to the agency right away. If necessary, transportation arrangements to the clinic are made. If this is not possible, the session is rescheduled as soon as possible. If patients cannot be reached for 2 days, an empathic letter of encouragement and concern is sent. All reasonable efforts should be made to retain patients in treatment. When patients return after an absence, problemsolving is conducted to prevent another similar absence.

Tardiness

Therapists should convey the attitude that sessions are important and patients should not waste time by being late. Assistance in helping patients solve any problems that contribute to tardiness should be offered. However, therapists should be careful to not punish attend-ance. Especially in the early stages of treatment, praise is offered for coming to the clinic even though late. If time is available, full sessions are conducted even if started later than scheduled.

Extra Sessions

Some patients will request extra sessions, particularly in the beginning of treatment. Therapists should try to meet such patient needs. Brief contacts can be scheduled or phone check-ins used to provide the additional support requested. The supervisor should be consulted to make decisions about how long additional support will be provided and how to handle more needy patients. Eventually, the goal is to reduce additional support and return to regularly scheduled sessions.

Note that by making a request, the patient is indicating that extra sessions are important (i.e., a potential reinforcer). Therefore, contracts could be written wherein the therapist agrees to extra meetings contingent on the patient completing certain goals.

Drug and Alcohol Use

Therapists should terminate any session in which patients are under the influence of alcohol or other drugs. This should be done in a caring but assertive manner. Therapists should explain that they are unable to provide the professional care that patients have requested when they are under the influence. Patients are encouraged to return for the next session sober.

Concurrent Treatment

Patients should not be enrolled in other professionally delivered treatments for alcohol or drug problems while enrolled in CRA + Vouchers. Multiple treatments can cause confusion because different treatment approaches may use different strategies. Patients may get mixed messages or may be unable to focus their energies sufficiently to benefit from CRA + Vouchers if engaged in other treatments.

Attendance at AA (Alcoholics Anonymous) or NA (Narcotics Anonymous) is often encouraged but not required. Some patients may choose to make self-help group attendance

one of their lifestyle change goals, and therapists often recommend participation in AA or NA as a way to increase social interaction with sober individuals.

Treatment for other psychiatric disorders or behavior problems is often encouraged. An important judgment here is whether the problem directly influences cocaine use. If so, it must be addressed in the context of CRA + Vouchers or through an appropriate referral. Clinical judgment must be used to determine if the benefits of seeking additional treatment outweigh the potential for such treatment to distract from the focus of CRA + Vouchers. If the problem is mild and not directly affecting cocaine use, patients may be encouraged to postpone additional services so they can focus their energy on one problem at a time. Clinical supervisors should be consulted in these cases.

Premature Termination

Therapeutic termination and referral should be considered for those cases in which continued regular cocaine or other drug use places the patient in serious physical or psychological danger. During this time of HIV/AIDS and other fatal consequences of cocaine abuse, treatment dismissal should be made only after thorough and careful clinical assessment. However, when the therapist and other clinical staff feel they have exhausted their skills and efforts but the patient fails to progress, it is time for a referral.

Also to be considered are psychiatric reasons for termination and referral, such as acute psychosis or severe suicidal ideation that requires hospitalization. Possible termination always needs to be balanced against recognition that cocaine dependence is a life-threatening disorder characterized by ambivalence and risky behavior that can make progress in treatment difficult.

Therapists must guard against making referrals or dismissals merely because of noncompliance. Cocaine abusers are at continuous risk, and a mandatory referral or dismissal may exacerbate that risk if it results in the patient not receiving any treatment. Such cases should be thoroughly discussed with the clinical supervisor and other staff.

The discharge of patients who stop attending treatment should be preceded by letters, phone contacts, and personal visits that convey a willingness to continue treatment or to provide referral options for treatment elsewhere. In the research on CRA + Vouchers, missing five consecutive scheduled urinalyses was a marker for termination from the program. This termination rule has never resulted in the discharge of a patient who wished to remain in treatment. Rather, it was used to provide a precise termination date for patients who simply stopped coming to treatment.

Documentation of Patient Contact

The following procedures are followed for documenting patient contacts.

- Intake assessment is completed within 2 weeks of first meeting.
- The treatment plan is completed within 1 week of the first meeting.
- Session notes are completed on the Progress Note form **(exhibit 3)** within 2 days of the counseling session. This form is designed to help the therapist stay focused on the treatment plan and to evaluate progress based on that plan. Note that the form is structured such that all aspects of the treatment plan are reviewed, active goals are specified, the measure by which to evaluate progress is designated, and progress is assessed each session.
- Notes from brief in-person and phone contacts are charted on the Brief Contact form **(exhibit 4)**.
- All professional contacts are charted on the Brief Contact form.
- Discharge summaries are completed within 2 weeks of discharge.

Clinical Supervision

Clinical supervision should be a component of this treatment for two reasons. First, CRA + Vouchers requires intensive services that target specific behavior changes. Unfortunately, many times CRA therapists may feel that they are working much harder than their patients. Patients may be noncompliant and refuse to follow through with many of the therapeutic tasks the therapists have worked so hard to set up. This scenario does not reinforce the therapists' hard work. Thus, it can naturally lead to a decrease in effort exerted by the therapist and foster negative feelings and pessimism concerning treatment. A supervisor who is not personally involved in administering the therapy can help the therapist remain motivated, creative, and positive.

Second, cocaine abusers enrolled in treatment have multiple problems, some directly related to cocaine and others that are not. Such patients often come to treatment sessions with a new crisis each week - some serious, others not so serious. These multiple problems and crises make it difficult for therapists to stay focused on the treatment plan. A supervisor can help therapists sort through these issues and can provide the structure, support, and encouragement to remain focused on the primary goal of treatment, cocaine abstinence.